U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 April 2007

CASE NO.: 2005-BLA-05870

In the Matter of

C.H.,
Claimant,

v.

SCOTTS BRANCH COAL CO.
c/o MAPCO COAL INC.,
Self-insured Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Steven A. Sanders, Esq.
For Claimant

Paul E. Jones, Esq.
For Employer

Before:

JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits filed pursuant to the Black Lung Benefits Act, 30 U.S.C. §901–945 ("the Act"), and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that title.[1]

[1]The Department of Labor ("DOL") has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at C.F.R. Parts 718, 722, 725, and 726 (2002). They are applicable to all claims pending on, or filed after that date. *See* 20 C.F.R. §718.101(b) (2001); 20 C.F.R. §725.2(c) (2001). As the instant claim was filed on March 17, 2004, the revised regulations apply to the claim. The United States Court of Appeals for the District of Columbia has upheld the validity of the revised regulations. *See National Mining Assoc. v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002).

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of the miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On May 12, 2005, this case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing. DX-42.[2] I held a hearing on August 8, 2006, in Pikeville, Kentucky, at which time the parties appeared and had full opportunity to present evidence and argument.

At the hearing, exhibits DX-1 through DX-44; CX-1 through CX-5; and EX-1 and EX-2 were admitted into evidence. Tr. at 5, 11, 14–16, 42. Subsequent to the hearing, Employer submitted Dr. Wheeler's reread of the June 22, 2006 chest X-ray identified as "EX-2." Employer also submitted a report by Dr. Fino dated September 5, 2006, and a report by Dr. Dahhan dated September 6, 2006, identified as EX-3 and EX-4, respectively.[3] Pursuant to my ruling at the hearing, these exhibits are now received into evidence. Tr. at 10. The record is now closed.[4]

Both Employer and Claimant submitted closing arguments on October 26, 2006 and November 3, 2006, respectively. The following decision is based upon a thorough review of the evidentiary record, the arguments of the parties, and an analysis of the applicable law.

I. ISSUES

1) Whether the claim was timely filed;

2) Whether Claimant can establish that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final pursuant to 20 C.F.R. §725.309(d) (i.e., whether Claimant has established a change in condition);

3) Whether Claimant has pneumoconiosis pursuant to 20 C.F.R. §718.202;

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[2]In this Decision and Order, "DX-#" refers to Director's Exhibits; "CX-#" refers to Claimant's Exhibits; "EX-#" refers to Employer's Exhibits; and "Tr. at-" refers to the Hearing Transcript of August 8, 2006.

[3]These were actually marked in error as "EX-2" and "EX-3" but have subsequently been identified as "EX-3" and "EX-4." In his brief, Claimant argues that Dr. Fino's and Dr. Dahhan's supplemental reports exceed the evidentiary limitations of the regulations. I find that both Dr. Dahhan's and Dr. Fino's second reports rebut Dr. Forehand's report and as such are permissible under the regulations. As I stated in my Order of July 28, 2006, Employer was permitted the opportunity to submit "an additional statement" from the physician who prepared the medical report explaining his conclusion in light of the contradictory evidence. 20 C.F.R. §725.414.(a)(2)(ii) and (3)(iii).

[4]At the hearing, Employer identified some of Claimant's treatment records from 1997 as "EX-2." These were not received into evidence at that time, however, nor have they been submitted subsequent to the hearing. Tr. at 41–42.

4) Whether Claimant's pneumoconiosis arose out of his coal mine employment pursuant to 20 C.F.R. §718.203;

5) Whether Claimant has a total pulmonary disability pursuant to 20 C.F.R. §718.204(b); and

6) Whether Claimant's total pulmonary disability is due to pneumoconiosis pursuant to §718.204(c).

DX-42; Tr. at 5–6.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural History

On April 27, 1988, Claimant filed his first claim for federal black lung benefits with the United States Department of Labor, Director of Workers' Compensation Programs ("OWCP" or "Director"). DX-1. In a Decision and Order issued on March 11, 1992, benefits were denied. ALJ Daniel L. Stewart found that Claimant did not have pneumoconiosis and that he was not entitled to benefits. The denial of benefits was affirmed by the Benefits Review Board ("Board") in an Order dated June 16, 1993.

On March 17, 2004, over a year later, Claimant filed his second claim. DX-3. By Proposed Decision and Order issued January 28, 2005, the OWCP Deputy Commissioner awarded benefits. DX-37. By letter dated February 10, 2005, Employer disagreed with the findings and requested a formal hearing. DX-38. That hearing was held before me on August 8, 2006.

B. Factual Background

1) Stipulations of the Parties

The parties have stipulated to the following issues and facts:[5]

1. Claimant was a miner;

2. Claimant has established 21 years of post-1969 coal mine employment;

3. Scotts Branch Coal Co. is the responsible coal mine operator; and

4. Claimant's wife is his only dependent for purposes of augmentation of benefits under the Act.

[5]At the hearing, Employer noted that upon hearing the testimony, both dependency and responsible operator would probably be withdrawn. Tr. at 6. As Employer made no mention of either of these issues in his brief, I have assumed that they were withdrawn.

Tr. 5–6. I find these stipulations are supported by the record and I adopt them as findings herein.

2) Testimony of Claimant and Claimant's Wife (Tr. at 18–51)

Claimant testified that he was born on August 21, 1937 and that he is 61 years old. He is married and has been since October 1, 1960. Tr. at 19; DX-14. Claimant stopped working in 1986 after he hurt his back setting roof bolts in the coal mine where he worked. Tr. at 19. He performed the work of a roof bolt operator for Scotts Branch Coal. He worked underground drilling holes into rock and he used a machine to tighten the bolts that would support the roof, and often had to work in small spaces on his knees. Tr. at 22. He lifted and carried bolts that were 4 to 8 feet long, carried steel plates and cables and ran shuttle cars. Tr. at 23, 28. He regularly breathed in coal and rock dust, and he would be "[b]reathing pretty hard" at the end of his shift. Tr. at 26.

Claimant uses medication for his breathing and relies on supplemental oxygen. Tr. at 28. He smoked ½ to 1 pack of cigarettes a day from the age of 19 until the age of 51. Tr. at 29. On cross-examination he stated that he has performed no coal mine employment since 1988. He also stated that if not for his back injury "I'd still be working today probably." Tr. at 30. He stated that when he worked underground he ran a motor and also performed general labor. Tr. at 30–31. In the first year that he worked for Scotts Branch Coal, he performed general labor and then bolted roofs. Tr. at 33. Claimant testified that sometime in 1989–1990, Dr. Fritzhand, Dr. Clarke, and Dr. Penman told him that he was totally disabled due to "black lung." Tr. at 37.

Claimant's wife testified that Claimant never smoked more than ½ to 1 pack of cigarettes a day. Tr. at 47. She also smoked approximately 3–4 cigarettes a day, but quit in 1997 after her husband had open heart surgery. Tr. at 48–49.

C. Timeliness of Claim

Employer asserts that the instant claim was not timely filed. Pursuant to the Act and regulations, a claim for benefits must be filed within three years after a medical determination of total disability due to pneumoconiosis is communicated to a miner. 20 C.F.R. §725.308. The regulations provide that "there shall be a rebuttable presumption that every claim for benefits is timely filed." 20 C.F.R. §725.308(c); *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 606 (6th Cir. 2001) ("[c]laims for black lung benefits are presumptively timely"). The party opposing entitlement must demonstrate that the claim is untimely and there are no "extraordinary circumstances" under which the limitation for filing should be tolled. *Daugherty v. Johns Creek Elkhorn Coal Corp.*, 18 B.L.R. 1-95 (1994). Furthermore, the Board has held that the three-year filing limitation period provided by §725.309 applies only to initial claims and not to subsequent claims, such as the instant one. *Stolitza v. Barnes and Tucker Co.*, 23 B.L.R. 1-93, 1-97, n.5. (2005). *Andryka v. Rochester & Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990); *Faulk v. Peabody Coal Co.*, 14 B.L.R. 1-18 (1990).

Employer argues that "[Claimant] long ago was diagnosed and information [sic] communicated to him that he had the disease and that a claim should have been filed." Employer's Brief at 4. Employer relies on the fact that Claimant testified that Drs. Fritzhand,

Clark, and Penman (physicians who submitted reports in association with Claimant's first claim) informed Claimant that he was totally disabled. Employer's Brief at 4; Tr. at 37. Claimant's first claim was filed timely, and those communications were associated with Claimant's initial claim, which was denied. I find that the communications made by these physicians do not apply to the instant claim, as that initial claim was denied. *Andryka v. Rochester & Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990) (statute of limitations applies only to the first claim filed). Moreover, the Sixth Circuit Court of appeals concluded that the timeliness standard relies upon the reasoned opinion of a physician that Claimant is disabled by black lung. *Kirk*, supra. The Board cites to this conclusion in holding that "a claimant's mere statement that he was told by a physician that he was totally disabled by black lung is insufficient to trigger the running of the statute of limitations". See, *Kessler v. Island Creek Coal Co.*, BRB No. 06-0629 BA (March 28 2007) (unpub.).

Employer also suggests that because Claimant has not worked in coal mine employment for almost 20 years, the claim is untimely, presuming that the reason Claimant has not worked is because of pneumoconiosis. Employer's Brief at 4–5. This argument lacks merit. Claimant has consistently asserted that his back injury is the reason he stopped working. In fact, at the hearing on August 7, 2006, Claimant was asked: "Would you have continued to work if you didn't have your back injury?" Claimant replied: "Oh, yeah. I'd still be working today probably." Tr. at 30. Whatever Claimant was told by any physician of record regarding the nature of his disability, it is not clear that he understood it to mean that he has a total pulmonary disability due to pneumoconiosis.

The presumption of timeliness has not been effectively rebutted by Employer. I find that the instant claim was timely filed.

D. <u>Entitlement</u>

Benefits are provided under the Black Lung Act for miners who are totally disabled due to pneumoconiosis. 20 C.F.R. §718.204(a). "Pneumoconiosis" is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. §718.201(a). Because this claim was filed after January 19, 2001, Claimant's entitlement to benefits will be evaluated under the revised regulations set forth at 20 C.F.R., Part 718. In order to establish entitlement to benefits under Part 718, a claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner has pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's pneumoconiosis contributes to his total disability. 20 C.F.R. §725.202(d)(2)(i)–(iv); *See Director, OWCP, v. Greenwich Collieries*, 512 U.S. 267 (1994); *Perry v. Director, OWCP*, 9 B.L.R. 1-1, 1-2 (1986).

This claim represents a subsequent claim filed pursuant to 20 C.F.R. §725.309(d) of the revised regulations. When a miner files a claim for benefits more than one year after the denial of a previous claim, the subsequent claim must also be denied unless it can be shown that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. §725.309(d); *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-53 (2004) (*en banc*). The "applicable conditions of entitlement" are "those conditions

upon which the prior denial was based." 20 C.F.R. §725.309(d)(2); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (*en banc*). If the miner demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim "shall be binding on any party in adjudication of the subsequent claim." 20 C.F.R. §725.309(d)(4). Claimant's prior claim was denied because ALJ Stewart determined that Claimant had not established the presence of pneumoconiosis. Consequently, if the newly submitted evidence establishes the presence of disease, I would then be required to review the entire record *de novo* to determine Claimant's entitlement to benefits. 20 C.F.R. §725.309(d)(4).

1) Presence of Pneumoconiosis

A finding of the existence of pneumoconiosis is determined pursuant to 20 C.F.R. §718.202. In addition, the regulations permit an ALJ to give appropriate consideration to "the results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis." 20 C.F.R. §718.107(a). Finally, the Board has held that all evidence relevant to the existence of pneumoconiosis must be considered and weighed. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986) (the Board upheld a finding that the claimant had not established the existence of pneumoconiosis even where the X-ray evidence of record was positive).

There are four means of establishing the existence of pneumoconiosis, set forth at §718.202(a)(1) through (4):

1. X-ray evidence. §718.202(a)(1);

2. Biopsy or autopsy evidence. §718.202(a)(2);

3. Regulatory presumptions. §718.202(a)(3);

   (a) §718.304—Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis;

   (b) §718.305—Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is no other evidence demonstrating the existence of a totally disabling respiratory or pulmonary impairment;

   (c) §718.306—Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978, and was employed in one or more coal mines prior to June 30, 1971.

4. Physicians' opinions based upon objective medical evidence. §718.202(a)(4).

§718.202(a)(1)–(4). In weighing the evidence falling within these subsections, the Board has noted that the United States Court of Appeals for the Sixth Circuit "has often approved the independent application of the subsections of 718.202(a) to determine whether claimant has established the existence of pneumoconiosis." *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).[6]

The following is a discussion of the §718.202(a) evidence of record.

1. Chest X-ray Evidence — §718.202(a)(1).

Pursuant to §718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with §718.102.[7] An ALJ may utilize any reasonable method of weighing X-ray evidence. *Sexton v. Director, OWCP*, 752 F.2d 213 (6th Cir. 1985). Generally, a physician's qualifications at the time he/she renders an interpretation should be considered. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985). It is well established that it is proper to credit the interpretation of a dually-qualified (B-reader and BCR) physician over the interpretation of a physician who is solely a B-reader. *Ziegler Coal Co. v. Director, OWCP [Hawker]*, 326 F.3d 894 (7th Cir. 2003) (complicated pneumoconiosis); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (*en banc on recon*); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 131 (1984). The Board has also held that greater weight may be accorded the X-ray interpretation of a dually-qualified physician over that of a physician who is only a BCR. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (March 23, 1995) (*unpublished*). In addition, an ALJ is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979).

The record contains the following newly submitted chest X-ray reports:

Date of X-Ray	Date Read	Exhibit No.	Physician	Radiological Credentials	Film Quality	Interpretation
(1)						
04/26/04	04/26/04	DX-16	Forehand	B-reader	1	1/0 (category s and

[6]Claimant's last coal mine employment took place in the state of Kentucky, and therefore, the law of the Sixth Circuit governs this claim. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

[7]A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. §37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(iii) (2001).

						p in all zones)
04/26/04	05/12/04	DX-17	Barrett	B-reader BCR	2 (position)	Quality only
04/26/04	07/01/04	DX-19	Wheeler	B-reader BCR	2 (improper position)	Negative
04/26/04	07/22/05	CX-1; CX-3	Miller	B-reader BCR	2	1/1 (category t and s in all zones)
(2)						
10/25/04	10/25/04	DX-36	Dahhan	B-reader	1	Negative
10/25/04	07/22/05	CX-2; CX-3	Miller	B-reader BCR	2	1/1 (category t and s in all zones)
(3)						
06/22/06	06/22/06	CX-4	Forehand	B-reader	1	1/1 (q opacities in all zones)
06/22/06	08/15/06	EX-2	Wheeler	B-reader BCR	2	Negative

The April 26, 2004 chest X-ray was interpreted as positive for pneumoconiosis by Dr. Miller, a dually-qualified physician, and by Dr. Forehand, a B-reader. It was read by one dually-qualified physician (Dr. Wheeler) as being negative. As a preponderance of the interpretations is positive, I find that this chest X-ray is positive for pneumoconiosis.

The October 25, 2004 chest X-ray was interpreted as negative by Dr. Dahhan, a B-reader, and as positive by Dr. Miller, a dually-qualified physician. I accord more weight to the opinion of the dually-qualified radiologist and find that this chest X-ray is positive for pneumoconiosis.

The June 22, 2006 chest X-ray was interpreted as positive by Dr. Forehand, a B-reader, and as negative by Dr. Wheeler, a dually-qualified physician. I accord more weight to the opinion of the dually-qualified radiologist and find that this chest X-ray is negative for pneumoconiosis.

I decline to give more weight to the most recent X-ray of record, as all of the X-rays of record were taken approximately within a two-year period. I find that the preponderance of the chest X-rays are positive for pneumoconiosis and, therefore, Claimant has established the existence of pneumoconiosis under §718.202(a)(1).

2. Biopsy or autopsy evidence — §718.202(a)(2).

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. 20 C.F.R. §718.202(a)(2). That method is unavailable here, because the record contains no such evidence.

3. Regulatory presumptions — §718.202(a)(3).

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis, a condition not present in the instant case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. As none of these presumptions are applicable, the existence of pneumoconiosis cannot be established pursuant to 20 C.F.R. §718.202(a)(3).

4. Physicians' opinions — §718.202(a)(4).

The fourth way to establish the existence of pneumoconiosis pursuant to §718.202(a) is set forth as follows in subparagraph (4).

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." §718.201(a)

The record contains the following newly submitted physician opinions:

J. Randolph Forehand, M.D. [DX-16; CX-4; CX-5]

Dr. J. Randolph Forehand is Board-certified in Allergy/Immunology and Pediatrics, and is a B-reader. Dr. Forehand performed a pulmonary examination on behalf of the Department of Labor on April 26, 2004, and summarized his findings in a report dated April 27, 2004. DX-16. Dr. Forehand reported Claimant's subjective complaints of daily white sticky phlegm, wheezing, dyspnea, cough, chest pain, and orthopnea. Dr. Forehand also documented Claimant's medical history of hospitalizations for pneumonia, congestive heart failure, stroke, back injury, back surgery, open heart surgery, vascular surgery, bladder cancer, and blood clot in the brain. Dr. Forehand noted a coal mine employment history of 36 years including Claimant's last job at Scotts Branch as a roof bolter, which was estimated to last for 9 years. Dr. Forehand noted that Claimant smoked a pack of cigarettes a day from 1962 until 2002. Upon physical examination, Dr. Forehand heard wheezing and diminished breath sounds in Claimant's lungs. He found that Claimant's chest X-ray was positive for pneumoconiosis and his arterial blood gas showed

"arterial hypoxemia." Claimant's pulmonary function study revealed an obstructive ventilatory pattern. There were no acute changes in Claimant's electrocardiogram. Dr. Forehand concluded that Claimant has pneumoconiosis due to his coal mine dust exposure. He based this diagnosis on history, physical examination, arterial blood gas, and chest X-ray. The doctor also diagnosed coronary artery disease due to atherosclerosis, and chronic bronchitis due to cigarette smoking. He concluded that Claimant had a significant respiratory impairment that would prevent Claimant from returning to his last coal mining job. The doctor found Claimant "[t]otally and permanently disabled".

DX-16. Regarding the cause of total disability, Dr. Forehand wrote:

> Claimant's shortness of breath is caused by airflow limitation from smoking cigarettes, arterial hypoxemia from overexposure to coal mine dust and poor circulation from coronary artery disease. The effects of each is [sic] additive and the three causes work together to severely impair lung function.

DX-16.

Dr. Forehand also treated Claimant at The Clinic in Virginia on June 22, 2006. CX-4. Claimant complained of shortness of breath upon any exertion, and described feeling "like someone was pulling a bag over his head or cutting his wind off." CX-4. Claimant underwent a physical examination, a chest X-ray, pulmonary function and arterial blood gas studies, and an electrocardiogram. Dr. Forehand observed that a chest X-ray was abnormal and found advanced chronic obstructive pulmonary disease, and arterial hypoxemia. Dr. Forehand also concluded that Claimant was totally disabled. He noted that Claimant had a history of asthma, that he smoked 1 pack of cigarettes a day for 45 years, and that he worked for 25 years in coal mine employment as a roof bolter. Dr. Forehand opined that while Claimant had asthma, he was experiencing shortness of breath even when he is not having an acute asthma attack. For this reason, he did not believe that Claimant's asthma was "currently provoking his complaints of daily, progressively worsening shortness of breath." CX-4. Dr. Forehand concluded that Claimant had chronic obstructive pulmonary disease due to cigarette smoking and to occupational risks he was exposed to as a roof bolter in a coal mine. Dr. Forehand elaborated that roof bolters are exposed to high levels of silica, not just coal mine dust. He concluded that Claimant's complaints of shortness of breath on exertion, 25-year history of coal mine employment, abnormal lungs findings on physical examination, chest X-ray, and arterial blood gas were sufficient to diagnose coal workers' pneumoconiosis. He reported that the degree of arterial hypoxemia rendered Claimant incapable of performing his previous coal mine work which involved lifting items weighing as much as 80 lbs.

Dr. Forehand testified by deposition on July 31, 2006. CX-5. Dr. Forehand diagnosed pneumoconiosis based on Claimant's work history, review of his systems, his abnormal lung sounds, arterial blood gas, and chest X-ray. CX-5, p.16. Dr. Forehand testified that Claimant's 2006 pulmonary function study was valid and reproducible. CX-5, p.20. The doctor noted that Claimant's pulmonary function improved somewhat after bronchodilators, but said that Claimant "still doesn't have much in the way of lung function." CX-5, p.13. Dr. Forehand also stated that

the results of both of his arterial blood gases were similarly abnormal and reflected a "serious lung disease." CX-5, p.22. Dr. Forehand opined that Claimant's smoking was the likely cause of his obstructive airways disease. However, Claimant's extensive exposure to coal mine dust, and in particular the silica that he was exposed to as a roof bolter, was a "poisonous combination." CX-5, p.24. When asked whether his opinion would change if the X-ray evidence were negative, Dr. Forehand stated that "[y]ou can … be certain or be confident that a miner has coal workers' pneumoconiosis, a negative x-ray notwithstanding." CX-5, p.24.

Dr. Forehand addressed varying coal mine employment histories reflected in his reports, saying that despite being incorrect in his assumption that Claimant had been a roof bolter the entire length of his coal mine employment, his ultimate conclusion regarding presence of pneumoconiosis was unchanged. CX-5, p.32. For purposes of his testimony, he stated that he assumed a 21-year coal mine employment history. CX-5, p.31. Dr. Forehand testified that he did not have a history of Claimant's asthma nor did he consider it when diagnosing Claimant.[8] CX-5, p.42. Dr. Forehand acknowledged that an asthmatic can have a severe pulmonary deficit without coal mine dust exposure. CX-5, p.43. Dr. Forehand agreed that a person with congestive heart failure can also have an abnormal arterial blood gas result, but he observed that Claimant was not in congestive heart failure at the time that the tests at issue were administered. CX-5, p.44. Dr. Forehand observed that Claimant was experiencing shortness of breath while he was employed as a coal miner, and concluded that this fact was a significant factor in his determination that both cigarette smoking and coal mine dust exposure were both responsible for Claimant's lung disease. CX-5, p.51.

A. Dahhan, M.D. [DX-36; EX-4]

Dr. A. Dahhan is Board-certified in Internal Medicine with a subspecialty in Pulmonary Disease, and is a B-reader. DX-36. He examined Claimant on October 25, 2004 and issued a report dated November 1, 2004, summarizing his findings. DX-36. Dr. Dahhan reported Claimant's subjective complaints of frequent wheezing and dyspnea on exertion, and noted that Claimant worked underground in coal mine employment for 30 years as a roof bolter. Dr. Dahhan recorded Claimant's smoking history of 44 pack-years and documented his history of coronary artery disease, arthritis, back pain, diabetes mellitus, renal failure, peptic ulcer disease, congestive heart failure, and hypothyroidism. Upon physical examination of Claimant's lungs Dr. Dahhan found the following: "increased AP diameter with hyper resonance to percussion. Auscultation revealed reduced air entry to both lungs with bilateral expiratory wheeze." Dr. Dahhan administered an arterial blood gas study that showed "minimum hypoxemia," and a spirometry which showed "severe obstructive ventilatory defect, air trapping," and overall "severe partially reversible obstructive ventilatory abnormality." Claimant's chest X-ray was negative for pneumoconiosis. Dr. Dahhan concluded as follows:

> There are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, obstructive abnormalities on pulmonary function testing with significant

[8] As summarized above, in Dr. Forehand's June 2006 report, he actually did note that Claimant had asthma as a child and that this was a "pertinent" piece of information.

> response to bronchodilator therapy and negative x-ray reading for pneumoconiosis.

The doctor concluded that Claimant had advanced chronic bronchitis and emphysema and further found that he was unable to perform his previous coal mine employment due to his pulmonary disability. Dr. Dahhan opined that Claimant's total disability was related to his history of cigarette smoking, with "no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis." DX-36.

In a report dated September 6, 2006, Dr. Dahhan reviewed Dr. Forehand's reports. EX-4. Dr. Dahhan wrote that:

> it is my conclusion that this patient has no evidence of legal pneumoconiosis based on the numerous chest x-rays for this disease; furthermore he has obstructive pulmonary disease which has caused him to be totally and permanently disabled; he also does not have legal pneumoconiosis since his obstructive lung disease has resulted from his bronchial asthma as documented by the history of that disease in childhood. The significant response to bronchodilators administration by Dr. Forehand as well as the treatment plan with bronchodilators administered by his physician indicate that his condition is responsive to such measures and is not a fixed defect, which is inconsistent with the permanent adverse affects of coal dust on the respiratory system.

EX-4. Dr. Dahhan also wrote: "The suggestion that patients with bronchial asthma have symptoms only during attacks of bronchospasms is not valid since bronchial asthma is a chronic condition which requires treatment with maintenance agents, otherwise, the only necessary treatments would be rescue therapy, which is, unfortunately, not the case with [Claimant]." EX-4.

Dr. Gregory Fino

Dr. Gregory Fino is a Diplomate of the American Board of Internal Medicine and Pulmonary Disease and is a B-reader. Dr. Gregory Fino reviewed the medical records existing in the current record. EX-1. In a report dated August 17, 2005, he found no evidence of "radiographic coal workers' pneumoconiosis," but did find that Claimant had a "disabling pulmonary impairment." He wrote:

> [t]here is both a fixed and a reversible compliment and the obstructive abnormality is severe. Also, there is variability in room air oxygenation that can be identified in the difference of blood gas values between 4/26/04 and 10/25/04.

> He is disabled as a result of cigarette smoking. I do not see objective evidence that coal mine dust was a clinically significant contributing factor to [Claimant's] respiratory impairment and disability.

EX-1.

In a second report dated September 5, 2006, Dr. Fino reviewed Dr. Forehand's June 22, 2006 report and his deposition testimony. In this report, Dr. Fino wrote that Claimant had "chronic obstructive bronchitis" that "is related to coal mine dust." EX-1. Dr. Fino also wrote that he agreed with Dr. Forehand that Claimant was totally disabled. In this report, Dr. Fino also invalidated Dr. Forehand's pulmonary function study of June 22, 2006.

Dr. Fino asserted that while a portion of Claimant's chronic lung obstruction was related to coal mine dust exposure, the effects of smoking were the cause of his total disability. The doctor distinguished the "effects of smoking from that of coal mine dust inhalation" by citing to several medical studies that addressed airways obstruction and coal mine dust inhalation. Dr. Fino wrote that some American studies showed that there was a direct correlation between the amount of coal dust inhaled and loss in FEV_1. Dr. Fino then opined that a portion of Claimant's obstructive abnormality was related to emphysema, and that there is a direct relationship between the amount of emphysema and the reduction in a given miner's FEV_1. He wrote that the decline in FEV_1 might not be significant in the average coal miner:

> However, it could be clinically significant if there was a moderate or profuse pneumoconiosis present because the amount of pneumoconiosis present correlates quite well with the amount of emphysema present. Therefore, it is very helpful to estimate the amount of clinical pneumoconiosis present in order to assess the contribution to the clinical emphysema from coal mine dust inhalation. The assessment of the amount of clinical pneumoconiosis is, of course, based on the standard medical testing procedures already in use and clinical pulmonary function studies.

Dr. Fino emphasized that the presence of emphysema does not automatically indicate the presence of a respiratory impairment and that "[i]ndividual susceptibility plays a big role in determining the effects of coal dust on lung function." He concluded:

> I do not believe that a clinically significant portion of this man's inspiratory impairment is attributed to coal mine dust. I believe that he would be as disabled as I find him now had he never stepped foot in the coal mines.

EX-3.

Discussion

Dr. Forehand diagnosed pneumoconiosis based on a variety of factors including a positive chest X-ray. Dr. Forehand also diagnosed COPD arising from cigarette smoking and coal mine dust exposure (i.e., legal pneumoconiosis). Dr. Fino diagnosed chronic bronchitis arising from coal mine dust exposure (i.e., legal pneumoconiosis). Employer has argued "[a]ny and every condition for which claimant has been diagnosed would not be considered under the reasoned medical analysis of either Dr. Fino or Dr. Dahhan [sic] legal pneumoconiosis." Employer's Brief at 6–7. However, I find that the record contradicts this argument. In his report of September 5, 2006, Dr. Fino specifically wrote that "[t]here is certainly a portion of this man's obstruction that is reversible and related to chronic bronchitis. This, in my opinion, is related to coal mine dust." EX-3. I find that this is equivalent to a finding of legal pneumoconiosis as provided by §718.201(a)(2). This subsection provides that legal pneumoconiosis is "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." §718.201(a)(2). Dr. Dahhan did not diagnose pneumoconiosis nor did he find the presence of any condition arising from coal mine dust exposure.

I find that Dr. Dahhan's opinion is poorly reasoned. He wrote that Claimant had no evidence of legal pneumoconiosis "based on the numerous chest x-rays." Presumably, Dr. Dahhan meant to write "clinical" pneumoconiosis—a diagnosis of legal pneumoconiosis can be made in the absence of positive chest X-ray evidence. In addition, I have found that the chest X-ray evidence is positive for pneumoconiosis, and Dr. Dahhan's opinion is compromised by not addressing positive X-ray evidence. Dr. Dahhan also reasoned that Claimant does not have legal pneumoconiosis because asthma is the cause of his pulmonary obstruction. This reasoning is flawed as the existence of asthma does not disprove the existence of pneumoconiosis. Dr. Dahhan apparently relies on the fact that Claimant showed a "significant response" to bronchodilator in the pulmonary function studies, thereby implicating asthma as the cause of Claimant's lung disease (i.e., asthma symptoms improve upon use of bronchodilators). As Dr. Forehand points out, however, Claimant's improved post-bronchodilator results still showed lung abnormalities and reduced lung function.[9] This is consistent with the conclusion that asthmatic symptoms might be improved post-bronchodilator, but other disabling conditions are still present. Assuming *arguendo* that Claimant's asthma currently contributes to his reduced lung function, such a finding alone is insufficient to detract from the other physician's respective diagnoses of pneumoconiosis. As I find Dr. Dahhan's opinion to be poorly reasoned, I accord it little weight.

I accord more weight to Dr. Forehand's explicit opinion, in which he diagnosed pneumoconiosis. I noted that he and Dr. Fino are in agreement that Claimant also has COPD/chronic bronchitis due to coal mine dust exposure, respectively. I accord some additional weight to Dr. Forehand's opinion because he treated Claimant. I find that his opinion is well-documented and supported by the objective test evidence. Dr. Fino's corroborative opinion on

[9]Although Dr. Forehand testified that he did not consider Claimant's asthma when diagnosing him, this assertion is actually incorrect as evidenced by his own June 2006 report. In this second report, Dr. Forehand specifically discussed Claimant's history of childhood asthma and the significance of that condition as it related to Claimant's assessment and evaluation.

the presence of pneumoconiosis is also entitled to weight. The latter physician opinions as they pertain to presence of pneumoconiosis are reasoned and supported.[10]

The preponderance of physician opinion evidence supports a positive finding of pneumoconiosis.

Based on the generally positive chest X-ray evidence and physician opinion evidence, Claimant has established that he has pneumoconiosis. In doing so, he has also established a change in an applicable condition of entitlement.

2) Pneumoconiosis Arising from Coal Mine Employment

The regulations provide that in order for a claimant to prevail on a claim for benefits under the Act, "it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment." 20 C.F.R. §718.203(a). There is a rebuttable presumption that the pneumoconiosis arose out of coal mine employment if a miner who is or was suffering from pneumoconiosis was employed for ten years or more in one or more coal mines. 20 C.F.R. §§718.203(b); 718.302.

In the instant case, Claimant has established 21 years of qualifying coal mine employment. Therefore, the regulatory presumption that his pneumoconiosis arose from that coal mine employment is triggered. No rebuttal evidence has been presented.

For the foregoing reasons, I find that Claimant has established this element of entitlement.

3) Total Disability

In addition to establishing the presence of coal workers' pneumoconiosis, in order for a claimant to prevail under the Act, he or she must establish that they are totally disabled due to a respiratory or pulmonary condition. 20 C.F.R. §718.204(a). A miner is considered totally disabled within the Act, if "the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

> (i) From performing his or her usual coal mine work; and
>
> (ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time."

[10]Employer asserts that Dr. Forehand relied on varying coal mine employment histories and suggests that this undermines Dr. Forehand's conclusion. Employer's Brief at 7. I disagree. Dr. Forehand made clear in his deposition testimony that with only 21 years of coal mine employment Claimant had sufficient exposure to coal mine dust to support a positive finding of pneumoconiosis. Tr. 50–51.

20 C.F.R. §718.204(b)(1)(i)–(ii). Nonpulmonary and nonrespiratory conditions that cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. §718.204(a); *see also Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991), *aff'd as Beatty v. Danri Corp. & Triangle Enterprises*, 49 F.3d 993, 1000 (3d Cir. 1995). Finally, §718.204(a) also provides that:

> If, however, a non-pulmonary or non-respiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition shall be considered in determining whether the miner is or was totally disabled [under the Act].

§718.204(a).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinions. 20 C.F.R. §718.204(b)(2)(i–iv). A presumption of total disability is not established by a showing of evidence qualifying under §718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary evidence of greater weight. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231.

a) Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, after accounting for sex, age, and height, produce a qualifying value for the FEV_1 test, and produce either a qualifying value for the FVC test or the MVV test, or produce a value of FEV_1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV_1, FVC, and the MVV tests are measured results less than or equal to values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718, 20 C.F.R. §718.204(b)(2)(i). *Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n.5, 13 B.L.R. 2-259 (3d Cir. 1990). Assessment of pulmonary function study results is dependent on Claimant's height, which was listed as ranging from 65.6 to 67 inches. Pursuant to *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983), an ALJ is required to resolve the height discrepancy contained in the record. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). An average of the reported heights produced a height of 66.10, which is adopted herein.

The record contains the following newly submitted pulmonary function studies:

Date	Ex. No.	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Effort	Qualifies
04/26/04	DX-16	Forehand	66 66"	1.50 1.67*	2.30 2.59*	— —*	65% 65%*	Good Good*	No No*
10/25/04	DX-36	Dahhan	67 65.5"	0.91 1.18*	1.62 1.98*	22 32*	56% 60%*	Good Good*	Yes Yes*

Date	Ex. No.	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Effort	Qualifies
06/22/06	CX-4	Forehand	68 67"	1.87 2.38*	1.03 1.26*	16 25*	55% 53%*	Good Good*	Yes Yes*

*Values obtained post-bronchodilator

In a report dated June 7, 2004, Dr. Bruce C. Broudy invalidated Dr. Forehand's April 26, 2004 pulmonary function study. DX-18. Dr. Broudy reported that Claimant's effort was not satisfactory as there was "a great deal of variation between the results of the FEV1 and FVC. Inspection of the trials indicates that his exhalation was not particularly forced or prolonged" DX-18. In his deposition of July 2006, Dr. Forehand, who administered the test, acknowledged that Claimant's effort was "not maximal," but opined that "the majority of [Claimant's] tracings were superimposeable which means that they were reproducible and were acceptable, for the purposes of this study." CX-5, p.14. As it is, this study did not produce qualifying results overall.

In his report dated September 5, 2006, Dr. Fino invalidated Dr. Forehand's pulmonary function study of June 22, 2006. EX-3. He wrote as follows:

> The spirometry was invalid because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings. There was also a lack of an abrupt onset to exhalation. The values recorded for this spirometry represent at least the minimal lung function that this man could perform and certainly not this man's maximum lung function. [citations omitted].
>
> The MVV was invalid. The individual breath volumes were shallow and less than 50% of the forced vital capacity, and the individual breath volumes were also erratic. The breathing frequency was less than 60 breaths per minute. The MVV value underestimates this man's true lung function and should not be used as medical evidence of respiratory impairment. [citations omitted].

EX-3.

In his deposition testimony of July 2006, Dr. Forehand testified that his June 22, 2006 pulmonary function study was valid and "if you'll look at his two best efforts, they were within five percent 5% of one another." CX-5, p.20.

Even accepting the opinions that Dr. Forehand's pulmonary function studies were invalid, and therefore, not probative Dr. Dahhan's remaining October 25, 2004 pulmonary function study supports a finding of total disability. The results of this test are presumptively valid, as Dr. Dahhan noted that Claimant's effort was good, no physician invalidated the results, and Dr. Dahhan himself relied upon the results for his conclusions. Notably, Dr. Dahhan's qualifying results are some of the lowest produced in the three studies. This study supports a finding of total disability.

Based on the foregoing, I find that the October 25, 2004 pulmonary function study supports a finding of total disability.

b) Arterial Blood Gas Studies

To establish total disability based on arterial blood gas studies, the test must produce the totals represented in the Appendix to 20 C.F.R. Part 718, 20 C.F.R. §718.204(b)(2)(ii).

The record contains the following newly submitted arterial blood gas studies:

Date	Ex. No.	Physician	Altitude	pCO_2	pO_2	Qualifies[11]
04/26/04	DX-16	Forehand	0 to 2999 ft.	33	51	Yes (67)
10/25/04	DX-36	Dahhan	0 to 2999 ft.	33.6	72.9	No (67)
06/22/06	CX-4	Forehand	0 to 2999 ft.	34	63	Yes (66)

*Values obtained post-exercise

In a report dated June 1, 2004, Dr. N.K. Burki validated the results of Dr. Forehand's April 26, 2004 arterial blood gas study. DX-16. Dr. Burki is Board-certified in Internal Medicine with a subspecialty in Pulmonary Disease.[12]

As the preceding table demonstrates, the record contains three arterial blood gas studies. Two of the studies produced qualifying results and one of those studies was validated by a third party. No exercise blood gases were administered.

The preponderance of arterial blood gas studies supports a finding of total disability.

c) Cor Pulmonale Diagnosis

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided heart failure. 20 C.F.R. §718.204(b)(2)(iii).

There is no evidence of cor pulmonale with right-sided congestive heart failure in the record. Accordingly, I find that Claimant has not demonstrated total disability pursuant to 20 C.F.R. §718.204(b)(2)(iii).

d) Reasoned Medical Opinion

The fourth method for determining total disability is through the reasoned medical judgment of a physician that a miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful employment. Such an opinion

[11] In order to qualify for total disability under arterial blood gas studies, Claimant's pO_2 value would have to be equal to or lower than the given pO_2 levels found in the "Qualifies" column of this chart.

[12] http://www.abms.org.

must be based on acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. §718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989).

Every physician of record diagnosed a total pulmonary disability and found that Claimant could not perform his previous coal mine employment. The objective data of record also supports a finding of total disability.

I find that Claimant has established that he has a total pulmonary disability.

4) Total Disability Due to Pneumoconiosis

The amended regulations at Part 725 mandate that a miner is eligible for benefits if his "pneumoconiosis contributed to [his] total disability." 20 C.F.R. §725.202(d)(2)(iv). A miner is considered totally disabled due to pneumoconiosis if the pneumoconiosis. "is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." 20 C.F.R. §718.204(c). Pneumoconiosis is a substantially contributing cause if it:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. §718.204(c)(1)(i)–(ii) (2001). Disability due to pneumoconiosis may be established by a documented and reasoned medical report. §718.204(c)(2). The United States Court of Appeals for the Sixth Circuit has held that a claimant must show that pneumoconiosis is more than an "infinitesimal" factor in the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 507 (6th Cir. 1997).

Although the physicians are in accord that Claimant has a total pulmonary disability, they disagreed about its cause. Dr. Forehand's opinion is that both Claimant's cigarette smoking and his coal mine dust exposure contribute significantly to his total disability. Dr. Forehand found that arterial hypoxemia rendered Claimant incapable of performing his previous coal mine work and that arterial hypoxemia was one of the bases for his diagnosis of pneumoconiosis. Dr. Forehand's opinion is reasoned and supported as he relied on a thorough medical and social history, including Claimant's cigarette smoking history, and history of asthma, in addition to objective data, medical treatment history, and physical examinations. I accord substantial weight to Dr. Forehand's opinion.

Dr. Dahhan did not diagnose coal workers' pneumoconiosis, and concluded that Claimant's smoking is the only cause of his total disability. Dr. Dahhan relied upon negative chest X-rays in addition to his conclusion that Claimant's obstructive defects showed improvement after bronchodilators were administered. This reasoning is flawed as I have found that the chest X-ray evidence is positive for pneumoconiosis. Dr. Dahhan did not sufficiently explain how Claimant's coal mine dust exposure did not contribute to his COPD. Moreover, two other physicians found evidence of chronic bronchitis/COPD due to coal mine dust exposure, the effects of which could be totally disabling even absent positive negative chest X-ray evidence. Although Claimant's pulmonary function study results showed improvement upon use of bronchodilators, Dr. Forehand credibly testified that the objective studies of record showed evidence of reduced lung function ("serious lung disease") despite such improvement.[13] I accord no weight to Dr. Dahhan's opinion for these reasons.

Dr. Fino found that Claimant's total disability was related to cigarette smoking alone. In his report, Dr. Fino described how various studies have found that the amount of clinical pneumoconiosis present in a given miner's lungs is relevant to the degree of emphysema, which in turn is relevant to determining impact on FEV_1. Ostensibly, reviewing the impact on FEV_1 would permit one to distinguish the effects of smoking from the effects of coal mine dust exposure in a given miner's total disability. In the instant case, Dr. Fino's conclusion hinges on his finding that Claimant's emphysema was not severe enough to have caused a significant reduction in his FEV_1. In his second report, Dr. Fino opined that a portion of Claimant's obstructive abnormality was related to emphysema. EX-3. However, Dr. Fino did not address how Claimant's diagnosed chronic bronchitis arising from coal mine dust exposure would factor into Claimant's pulmonary disability, regardless of chest X-ray evidence. I find that Dr. Fino's opinion is poorly reasoned on the issue of causation of total disability.

Dr. Forehand's opinion is the best documented and reasoned of record. I find that it establishes that Claimant's total disability is due to coal workers' pneumoconiosis.

E. Subsequent Claim and Change in Condition

As Claimant has established an element of entitlement (i.e., that he has pneumoconiosis), that was previously decided against him, he has established a change in condition. Therefore, I have reviewed all the evidence relating to his prior claim for benefits under the Act, which I incorporate by reference into this record, and which is found in DX-1.

The medical evidence associated with Claimant's prior claim was developed before 1990—over 17 years ago. The previously submitted evidence as a whole did not support a finding of pneumoconiosis. However, as pneumoconiosis is a progressive and irreversible disease, I find it more appropriate to accord more weight to the newly submitted, and more current, positive chest X-rays and to the newly submitted, and more current physician opinions.

[13]In fact, Dr. Dahhan's own post-bronchodilator results of his 10/25/04 study qualified for total disability under the regulations. DX-36.

Clark v. Karst-Robbins Coal Co, 12 B.L.R. 1-149 (1989) (*en banc*). In addition, the current physician opinion evidence is unanimous that Claimant now has a total pulmonary disability. In contrast to the previously submitted evidence, the current pulmonary function and arterial blood gas studies produced qualifying results and support the current unanimous physician opinion evidence as well.

In reviewing the record in its entirety, my finding that Claimant is totally disabled due to coal workers' pneumoconiosis is unchanged.

III. CONCLUSION

Based on the newly submitted evidence, Claimant has established that he has pneumoconiosis arising from coal mine employment. In so doing, Claimant has established a change in an applicable condition of entitlement pursuant to §725.309(d). In reviewing the record *de novo*, I find that Claimant has proven that he is totally disabled due to his coal workers' pneumoconiosis, and that he is entitled to benefits under the Act.

Benefits are payable to a miner who is totally disabled due to pneumoconiosis beginning with the month of onset of disability. Where onset cannot be determined, benefits commence with the date the claim was filed. §725.503(b). I find that the evidence of record does not establish the date of onset of Claimant's disability. Therefore, benefits shall commence as of March, 2004, the month and year in which the claim was filed.

IV. ATTORNEY'S FEES

No award of attorney's fees for services to Claimant is made herein because no fee application has been received. Thirty (30) days is hereby allowed Claimant's counsel for the submission of a fee application, which must conform to §§725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties including Claimant must accompany the application. Parties have ten (10) days following receipt of any such application within which to file any objection. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of C.H. for benefits under the Act is hereby AWARDED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).